# Salary Reduction Contributions Enrollment Form

## Employee Information

Professional Staffing Group
Employer Name

______________________________________
Employee name (last, first, middle)

______-____-_______
Social Security Number

______________________________________
Employee Street address

**02/2010 to 01/2011**
Plan year

______________________________________
City State Zip

## Pre-tax premium elections

*Listed below are the benefit(s) that may be available under the P. O. P. Plan. Please indicate the benefit(s) you elect to deduct pre-tax by checking the box next to the applicable benefit.*

Benefits (X)
[X] Medical $___________

## Authorization

I authorize the adjustment to my annual base salary based on my election(s) above. I understand that by signing and submitting this form I am making a binding election for that plan year as stated unless such revocation or new election is on account of and consistent with a change in status (e. g., marriage, divorce, death, and termination of employment of spouse). I further understand that this form must be signed and dated prior to my plan effective date in order to be eligible to participate in this plan year.

______________________________________
Signature Date: ____/___/____

## Declination

The benefits of the plan have been thoroughly explained to me and I decline to participate. I understand that I cannot re-enroll until the beginning of the year or until I experience a change in status that would allow me to change my election.

______________________________________
Signature Date: ____/___/____